CHICAGO — Endocrinologists are “be- hind the curve” when it comes to treating osteoporosis, Dr. Nelson B. Watts said at the annual meeting of the American Asso- ciation of Clinical Endocrinologists.

“Endocrinologists are several years behind in terms of treatment of the disorder, according to Dr. Watts, who consults for and receives grants from a number of pharmaceutical companies. “The National Osteoporosis Foundation, ACEe, and the North American Menopause Society are all in agreement that patients with T scores of –1.5 or lower should be treated for phar- macologic treatment,” he said. “And they all agree that those with T scores of –2.5 or below should be treated even in the ab- sence of risk factors.”

The National Osteoporosis Foundation says that if the patient has risk factors for osteoporosis—such as previous fractures and advanced age—and her T score is be- tween –1.5 and –2, the physician should go ahead and treat the patient. The doctor also should treat the patient if the “T score is –2 or below, even in the absence of risk factors, the foundation says. AACE sug- gests treating patients whose T scores are between –1.5 and –2 but not present, while the North American Menopause Society advocates no treat- ment if the T score is between –1.5 and –2 but suggests that patients between –2 and –2.5 should be treated if risk factors are present, Dr. Watts said.

How should physicians handle this “gray zone”? “The problem with treating only pa- tients with T scores of –4.5 or below is that there are patients above –2.5 who ac- tually have a fairly high 10-year probability of fracture, and unless we’re smart enough to recognize what the right risk factors are, many of those pa- tients aren’t being treated,” said Dr. Watts.

The most recent thinking is toward mov- ing away from just using T scores and calling “absolute fracture risk” or “absolute frac- ture probability,” he continued. “This will consider bone density, but in countries that have little or no access to bone density [measurement] systems, it’s the only way to think about it.”

Dr. Watts offered these tips on manag- ing patients with a high fracture risk: 

— Consider hip protectors and assistive devices. There are conflicting data on whether using hip protectors reduces the risk of fracture. But physicians who are in- terested in recommending them can easily find them on the Internet.

— Be judicious with pharmacologic therapy. Dr. Watts said bone drugs such as alendronate, raloxifene, ibandronate, rise- dronate, and calcitonin are only shown to reduce the risk of fracture in patients with low bone density, and are not appropriate if the risk is due to poor eyesight, poor hear- ing, poor balance, and muscle weakness.

— Advocate exercise. “Weight-bearing exercise is important,” he said. “I recom- mend patients walk for 30-40 minutes a day, 3-4 sessions per week.”

— Remember that when it comes to cal- cium, more is not always better. The op- timal calcium intake is 1,200 mg per day for adults aged 50 and older, he noted. The average adult gets only half of what is needed from the diet, so most people take a supplement; 700-1,000 mg per day should be adequate. But many people take too much. “I see patients who are taking in 3,000-5,000 mg of calcium per day,” he said. “A safe limit is 30–40 mg per meal, or less.” He added, “Many pa- tients require 1,000-2,000 IU of vitamin D per day to achieve this level.”

## Osteoporosis Treatment Guidance Changing

**BY JOYCE FRIEDEN**

Associate Editor, Practice Trends

at the University of Cincinnati. “In academic centers, endocrinologists are of- ten the ‘boneheads,’ but in clinical prac- tice, rheumatologists compared with en- docrinologists are better at considering factors that are important in the treatment of osteoporosis.”

Osteoporosis is a “pretty good example of a disease for which treatment for the disorder, according to Dr. Watts, who consults for and receives grants from a number of pharmaceutical companies. “The National Osteoporosis Foundation, ACEe, and the North American Menopause Society are all in agreement that patients with T scores of –1.5 or lower should be treated for pharmacologic treatment,” he said. “And they all agree that those with T scores of –2.5 or below should be treated even in the absence of risk factors.”

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